COPY

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In The Matter of Charges and

Complaint Against

STELLA YI CHOU, M.D.,
PAUL E. CUTARELLI, M.D.,
& ANAMIKA JAIN, M.D.,

Respondents.

NO. **Case No. 08-29655-1**

FILED December 19, 2008

CLERK OF THE BOARD

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FIRST AMENDED COMPLAINT

The Investigative Committee of the Nevada State Board of Medical Examiners, composed of Charles N. Held, M.D., Chairman, Benjamin Rodriguez, M.D., Member, and Jean Stoess, M.A., Member, by and through Lyn E. Beggs, General Counsel for the Nevada State Board of Medical Examiners, having a reasonable basis to believe that Stella Yi Chou, M.D., hereinafter referred to as Dr. Chou, Paul E. Cutarelli, M.D., hereinafter referred to as Dr. Cutarelli, and Anamika Jain, M.D., hereinafter referred to as Dr. Jain, have violated the provisions of NRS Chapter 630, hereby issues its formal Complaint, stating the Investigative Committee's charges and allegations, as follows:

1. Respondents are licensed in active status to practice medicine in the State of Nevada, and at all times alleged herein, was so licensed by the Nevada State Board of Medical Examiners, pursuant to the provisions of Chapter 630 of the Nevada Revised Statutes.

2. Valley Eye Center, 2931 Tenaya Way, Suite 204, in Las Vegas, Nevada originally opened in approximately August 2006 as "Clinique Optique". On or about October 5, 2006, Valley Eye Center began providing refractive surgery to correct refractive errors of the eye, more commonly

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known as "Lasik." The practice of Valley Eye Center was limited exclusively to the providing of Lasik.

3. The owner and administrator of the facility is purported to be Anamika Jain, M.D. Dr. Anamika Jain is married to Vikas Jain. Dr. Anamika Jain is not an ophthalmologist. Dr. Anamika Jain's specialty is shown in the Board's records to be Rehabilitation Medicine.

4. Vikas Jain had been licensed as a physician, specializing in ophthalmology, in Ohio, New York, and Florida. On November 14, 2005, the State Medical Board of Ohio revoked Vikas Jain's license to practice medicine. The Ohio Board's order found, among other things, that Vikas Jain had committed ophthalmological malpractice upon 22 specific patients, resultant from his failure to properly preoperatively assess the patients, resulting in ophthamological surgical errors that caused harm to the 22 patients. Subsequent to the revocation of his license by the State Medical Board of Ohio, the medical licenses of Vikas Jain in New York and Florida were surrendered after both states filed disciplinary proceedings against him based upon the Ohio action. Vikas Jain has no active license to practice medicine in any state in the United States. Vikas Jain has not applied for a license to practice medicine in Nevada.

5. In October 2006, Dr. Chou began performing refractive eye surgeries at Valley Eye Center. Dr. Chou lives in Utah and maintains no residence or presence in Nevada except that she performed surgeries at Valley Eye Center. Dr. Chou was not employed by Valley Eye Center; instead, Dr. Chou is an employee of CompHealth, a physician recruiting and temporary placement service based out of Salt Lake City, UT.

6. The normal practice at Valley Eye Center was that on Mondays, Tuesdays, Wednesdays, and Thursdays, patients were seen at Valley Eye Center for pre-operative measurements and assessments in preparation for Lasik and to determine if patients were good candidates for the procedure. For at least five months during the time that Dr. Chou performed Lasik at Valley Eye Center, there was no licensed ophthalmologist or optometrist on the premises Monday through Thursday. Almost all of the preoperative measurements were completed by medical technicians. Some of the examinations, measurements and assessments performed by the technicians should only have been performed by a licensed ophthalmologist or optometrist. Most of the

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preoperative examinations, measurements and assessments were completed by Vikas Jain who was known to represent himself to patients as "Dr. Ken." In this role Vikas Jain would perform preoperative assessments, measurements and examinations of patients' eyes in preparation for the patients' Lasik surgery. Dr. Chou was not present at Valley Eye Center when technicians performed measurements or when Vikas Jain performed medical examinations and/or assessments on patients' eyes, and she exerted no supervisory oversight or control over the work of Vikas Jain or the medical technicians. On Thursday evenings, someone from Valley Eye Center would pick up Dr. Chou at the airport and drive her to her hotel room. Dr. Chou would be presented with a pile of patient files for the surgeries she would perform at Valley Eye Center. All of the preoperative assessments and measurements contained in the patient files would have been performed by medical techs and/or Vikas Jain, a/k/a Dr. Ken. Additionally, for every patient scheduled for surgery on a Friday, Vikas Jain diagnose whether the patient was an appropriate candidate for Lasik surgery, a diagnosis that only a licensed optometrist or ophthalmologist can make. The next morning, always a Friday, Dr. Chou would perform the Lasik eye surgeries using a Nidek machine provided by Valley Eye Center. Nidek machines require the use of precise measurements to assure the proper outcome of the surgery and may not be used on dilated eyes. The measurements Dr. Chou would use with the Nidek machine would be the measurements provided to her by Vikas Jain or the other medical technicians. Dr. Chou performed no independent assessment or measurement of any patients' eyes and would make a final diagnosis and decision to proceed forward with the procedure solely on the information provided to her by others. Often Dr. Chou also failed to meet independently with patients to discuss their impending refractive eye surgeries and instead would meet with a number of patients in group format to discuss their surgeries. Dr. Chou would perform a large number of surgeries all day on Fridays and would perform additional surgeries if necessary on Saturdays. At some time on each Saturday, Dr. Chou would fly back to her home in Utah. During Dr. Chou's tenure at Valley Eye Centery, almost all postoperative care would be provided by Vikas Jain during the time that Dr. Chou performed surgeries at Valley Eye Center.

7. Pursuant to this normal mode of practice, Dr. Chou performed Lasik surgery upon the eyes of Patients A, B, C, D, E, F, G, H, I, J, K, L, and M. Prior to surgery, Dr. Chou did no

independent examinations of Patients A through M. The only guidance for the surgeries were the assessments and measurements on Patients A through M conducted by Vikas Jain and other medical technicians and Dr. Chou did no independent evaluations of each patient to determine their candidacy for the Lasik procedure.

CAUSES OF ACTION RELATED TO DR. CHOU

First Cause of Action

8. All of the above paragraphs are incorporated by reference as though fully set forth herein.

9. Patient A had double vision and wore glasses with prisms. Unbeknownst to Patient A, he was not an appropriate candidate for Lasik surgery, but the procedure was performed by Dr. Chou on February 7, 2007 pursuant to the normal mode of practice at Valley Eye Center described in paragraph #6 and #7 herein

10. NAC 630.040 defines malpractice as failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.

11. NRS 630.301(4) provides that malpractice is grounds for initiating disciplinary action against a licensee.

12. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances, by physicians in good standing practicing ophthalmology in Nevada when she performed the Lasik surgery upon Patient A in the manner described. As a consequence of Dr. Chou's failure to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances, subsequent to the procedure, Patient A suffered difficulties in focusing and continues to experience pain around the left eye and occipital bone.

13. Dr. Chou's treatment of Patient A as alleged constitutes a violation of NRS 630.301(4) and thus she is subject to disciplinary action being taken against her.

Second Cause of Action

14. All of the above paragraphs are incorporated by reference as though fully set forth herein.

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15. Pursuant to the normal mode of practice at Valley Eye Center described in paragraph #6 and #7 herein, Patient B had Lasik surgery performed by Dr. Chou on January 12, 2007 on both of her eyes in order to create monovision. Prior to the surgery, Dr. Chou did no examination of Patient B's eyes.

16. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances by physicians in good standing practicing ophthalmology in Nevada when she performed the Lasik surgery upon Patient B in the manner described. As a consequence of Dr. Chou's failure to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances, Patient B suffered continuing eye issues including vision problems.

17. Dr. Chou's treatment of Patient B as alleged constitutes a violation of NRS 630.301(4) and thus she is subject to disciplinary action being taken against her.

Third Cause of Action

18. All of the above paragraphs are incorporated by reference as though fully set forth herein.

19. Patient C presented to Valley Eye Center in August 2006 for pre-operative evaluations and assessments for Lasik surgery. Patient C's Lasik surgery was performed by Dr. Chou on October 6, 2006, her first day performing procedures at Valley Eye Center, pursuant to the practices set forth in paragraphs # 6 and #7.

20. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances by physicians in good standing practicing ophthalmology in Nevada when she performed the Lasik surgery upon Patient C in the manner described. As a consequence of Dr. Chou's failure to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances, Patient C suffered excruciating pain due to a dislocated flap, which was repaired by Vikas Jain the day following the surgery, because Dr. Chou was unavailable as she had already left Las Vegas to return home to Utah.

21. Dr. Chou's treatment of Patient C as alleged constitutes a violation of NRS 630.301(4) and thus she is subject to disciplinary action being taken against her.

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Fourth Cause of Action

22. All of the above paragraphs are incorporated by reference as though fully set forth herein.

23. On or about January 12, 2007, Patient D presented to Valley Eye Center for Lasik surgery which was performed by Dr. Chou in the manner described in paragraphs #6 and #7.

24. During a post-operative visit, Patient D was seen by Vikas Jain who wrote a prescription for Patient D on Dr. Chou's prescription pad for Prednisone and forged Dr. Chou's name on the prescription in the presence of Patient D.

25. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances by physicians in good standing practicing ophthalmology in Nevada when she performed the Lasik surgery upon Patient D in the manner described and failed to personally perform any pre- or post-operative examinations. Additionally, Dr. Chou allowed her prescription pad to be used by an employee of Valley Eye Center, including the issuance of a prescription for Patient D on which Dr. Chou's signature was forged apparently with Dr. Chou's knowledge and assent. As a consequence of Dr. Chou's failure to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances, Patient D suffers from continued eye pain and is legally blind in his left eye.

26. Dr. Chou's treatment of Patient D as alleged constitutes a violation of NRS 630.301(4) and thus she is subject to disciplinary action being taken against her.

Fifth Cause of Action

27. All of the above paragraphs are incorporated by reference as though fully set forth herein.

28. On or about January 12, 2007, Patient E underwent Lasik surgery to correct nearsightedness at Valley Eye Center. The procedure was performed by Dr. Chou pursuant to the procedures set forth in paragraphs #6 and #7.

29. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances by physicians in good standing practicing ophthalmology in Nevada when she performed the Lasik surgery upon Patient E in the manner described. As a consequence of

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Dr. Chou's failure to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances, Patient D suffers from double vision and continued blurry eyes.

30. Dr. Chou's treatment of Patient E as alleged constitutes a violation of NRS 630.301(4) and thus she is subject to disciplinary action being taken against her.

Sixth Cause of Action

31. All of the above paragraphs are incorporated by reference as though fully set forth herein.

32. On or about March 9, 2007, Patient F presented to Valley Eye Center for Lasik surgery. Pursuant to the procedures set forth above in paragraphs #6 and #7, Dr. Chou performed the Lasik surgery.

33. On or about March 6, 2008, Patient F returned to Valley Eye Center for an enhancement procedure due to her eyesight being worse than prior to the surgery. Again, Dr. Chou performed the procedure pursuant to the normal method of practice described above.

34. Patient F developed an inflammation of her eyes post-operatively. Dr. Chou allowed Dr. Millie, an optometrist to write a prescription for Patient F on Dr. Chou's prescription pad for oral and topical steroids. Dr. Millie forged Dr. Chou's signature on the prescription and presented the forged prescription to Patient F apparently with Dr. Chou's knowledge and assent.

35. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances by physicians in good standing practicing ophthalmology in Nevada when she performed the Lasik surgery upon Patient F in the manner described and failed to personally perform any pre- or post-operative examinations and allowed her prescription pad to be used by another individual. As a consequence of Dr. Chou's failure to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances, Patient F now has extremely small corneas and may have to undergo cornea transplants in both eyes.

36. Dr. Chou's treatment of Patient F as alleged constitutes a violation of NRS 630.301(4) and thus she is subject to disciplinary action being taken against her.

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Seventh Cause of Action

37. All of the above paragraphs are incorporated by reference as though fully set forth herein.

38. Patient G had extreme astigmatisms. Unbeknownst to Patient G she was not an appropriate candidate for Lasik surgery, however, on or about June 29, 2007, Dr. Chou performed Lasik surgery on Patient G at Valley Eye Center pursuant to the procedures discussed in paragraphs #6 and #7. Dr. Chou did not perform a pre-operative assessment of Patient G.

39. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances by physicians in good standing practicing ophthalmology in Nevada when she performed the Lasik surgery upon Patient G in the manner described. As a consequence of Dr. Chou's failure to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances, Patient G suffers from continued eye pain, has been diagnosed with ectasia, severe dry eye and she may require corneal transplants.

40. Dr. Chou's treatment of Patient G as alleged constitutes a violation of NRS 630.301(4) and thus she is subject to disciplinary action being taken against her.

Eighth Cause of Action

41. All of the above paragraphs are incorporated by reference as though fully set forth herein.

42. On or about June 9, 2007, Patient H presented to Valley Eye Center for Lasik surgery which was performed by Dr. Chou pursuant to the procedures described in paragraphs # 6 and #7. Dr. Chou failed to perform any independent pre-operative examination of Patient H. Unbeknownst to Patient H, he was not an appropriate candidate for Lasik surgery due to his pupil size.

43. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances by physicians in good standing practicing ophthalmology in Nevada when she performed the Lasik surgery upon Patient H in the manner described. As a consequence of Dr. Chou's failure to use the reasonable care, skill, or knowledge ordinarily used under similar

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circumstances, Patient H's continues to suffer from severe dry eye, photophobia and experiences floaters.

44. Dr. Chou's treatment of Patient H as alleged constitutes a violation of NRS 630.301(4) and thus she is subject to disciplinary action being taken against her.

Ninth Cause of Action

45. All of the above paragraphs are incorporated by reference as though fully set forth herein.

46. On our about June 28, 2007, Patient I presented to Valley Eye Center for Lasik surgery which was performed by Dr. Chou pursuant to the procedures described in paragraphs #6 and #7.

47. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances by physicians in good standing practicing ophthalmology in Nevada when she performed the Lasik surgery upon Patient I in the manner described. As a consequence of Dr. Chou's failure to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances, Patient M's continues to suffer from eye pain and has a blind spot in her eye.

48. Dr. Chou's treatment of Patient I as alleged constitutes a violation of NRS 630.301(4) and thus she is subject to disciplinary action being taken against her.

Tenth Cause of Action

49. All of the above paragraphs are incorporated by reference as though fully set forth herein.

50. In January 2008, Patient J presented to Valley Eye Center for Lasik surgery. Pursuant to the procedures described in paragraphs #6 and #7, Dr. Chou performed the procedure. Dr Chou never met with Patient J prior to the procedure. Patient J did meet with Dr. Chou during one of his post-operative visits and he was diagnosed with epithelial in-growth and was prescribed steroid drops by Dr. Chou.

51. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances by physicians in good standing practicing ophthalmology in Nevada when she performed the Lasik surgery upon Patient J in the manner described. As a consequence

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of Dr. Chou's failure to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances, Patient J was told by another physician that he would be required to have the epithelial cells scraped from under his corneal flaps.

52. Dr. Chou's treatment of Patient J as alleged constitutes a violation of NRS 630.301(4) and thus she is subject to disciplinary action being taken against her.

Eleventh Cause of Action

53. All of the above paragraphs are incorporated by reference as though fully set forth herein.

54. In March 2008, Patient K presented to Valley Eye Center for Lasik surgery on her left eye. Dr. Chou performed the surgery pursuant to the procedures set forth in paragraphs #6 and #7.

55. Post-operatively Patient K was experiencing continued pain in her eye and after meeting with an optometrist at Valley Eye Center, sought a second opinion from another physician not associated with Valley Eye Center where epithelial in-growth of cells was discovered as well as a gouge to her eye.

56. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances by physicians in good standing practicing ophthalmology in Nevada when she performed the Lasik surgery upon Patient K in the manner described. As a consequence of Dr. Chou's failure to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances, Patient I was required to undergo a lengthy repair surgery resulting in eighteen stitches and best corrected vision of 20/100.

57. Dr. Chou's treatment of Patient K as alleged constitutes a violation of NRS 630.301(4) and thus she is subject to disciplinary action being taken against her.

Twelfth Cause of Action

58. All of the above paragraphs are incorporated by reference as though fully set forth herein.

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59. On or about March 27, 2008, Patient L presented to Valley Eye Center for Lasik surgery for the correction of farsightedness. Pursuant to the procedures set forth above in paragraphs #6 and #7, Dr. Chou performed the refractive surgery.

60. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances by physicians in good standing practicing ophthalmology in Nevada when she performed the Lasik surgery upon Patient L in the manner described. As a consequence of Dr. Chou's failure to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances, Patient L suffered from an infection under the cornea and will require corneal transplants due to the infection.

61. Dr. Chou's treatment of Patient L as alleged constitutes a violation of NRS 630.301(4) and thus she is subject to disciplinary action being taken against her.

Thirteenth Cause of Action

62. All of the above paragraphs are incorporated by reference as though fully set forth herein.

63. On or about May 15, 2008, Patient M presented to Valley Eye Center for Lasik surgery which was performed by Dr. Chou pursuant to the procedures discussed in paragraphs #6 and #7.

64. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances by physicians in good standing practicing ophthalmology in Nevada when she performed the Lasik surgery upon Patient M in the manner described. As a consequence of Dr. Chou's failure to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances, Patient M's vision was over corrected and her vision has changed from being nearsighted to farsighted.

65. Dr. Chou's treatment of Patient M as alleged constitutes a violation of NRS 630.301(4) and thus she is subject to disciplinary action being taken against her.

Fourteenth Cause of Action

66. All of the above paragraphs are incorporated by reference as though fully set forth herein.

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67. The diagnosis and determination of candidacy for Lasik surgery and several of the pre-operative examinations performed to make this diagnosis and determination are the practice of medicine and may only be performed by a licensed ophthalmologist or optometrist.

68. Dr. Chou knew that Vikas Jain was not a licensed physician or optometrist in Nevada and was aware that from August 2006 through March 2007, there was no licensed ophthalmologist or optometrist at Valley Eye Center performing pre- or post-operative examinations.

69. In performing Lasik surgeries at Valley Eye Center, Dr. Chou relied solely upon preoperative assessments and measurements and candidacy diagnoses made by persons whom Dr. Chou knew were not physicians or optometrists licensed in Nevada. In so doing, Dr. Chou aided, assisted, and knowingly allowed unlicensed persons, namely Vikas Jain to engage in the practice of medicine contrary to the provisions of NRS chapter 630.

70. Dr. Chou's aiding, assisting, and knowingly allowing Vikas Jain to perform pre-operative examinations on patients' eyes that should only be performed by an ophthalmologist or optometrist and allowing Vikas Jain to make diagnoses and determinations regarding the candidacy of some patients for Lasik surgery, acts which constitute the practice of medicine in Nevada, constituted a violation of NRS 630.305(1)(e) and accordingly Dr. Chou is subject to disciplinary action being taken against her.

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Fifteenth Cause of Action

71. All of the above paragraphs are incorporated by reference as though fully set forth herein.

72. Vikas Jain had had all of his medical licenses revoked as a result of his substandard ophthamological Lasik performed upon at least 22 patients in Ohio who had suffered substantial harm resultant from his substandard care. Vikas Jain, therefore, had been found by a board of his peers to be unqualified to perform ophthalmic functions related to Lasik surgery.

73. NRS 630.305(1)(f) provides that delegating responsibility for the care of a patient to a person a licensee knows, or has reason to know, is not qualified to undertake that responsibility is grounds for initiating disciplinary action against the licensee.

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74. Dr. Chou delegated responsibility for preoperative assessment and measurement of patients' eyes to Vikas Jain, meaning that she delegated responsibility for the care of her patients to a man who was known to be unqualified to be involved in the care of patients seeking Lasik.

75. Dr. Chou's delegating the responsibility for preoperative evaluations that should only be performed by a licensed ophthalmologist or optometrist and diagnosis and determination of candidacy for the procedure to Vikas Jain when she knew him to be unqualified to perform such tasks constitutes a violation of NRS 630.350(1)(f).

Sixteenth Cause of Action

76. All of the above paragraphs are incorporated by reference as though fully set forth herein.

77. NRS 630.306(2)(b) provides that engaging in conduct with the Board has determined is a violation of the standards of practice established by regulation of the Board is grounds for initiating discipline against a licensee.

78. NAC 630.230(1)(i) provides that a physician shall not fail to provide adequate supervision of a medical assistant who is employed or supervised by the physician or physician assistant.

79. The medical "technicians" at Valley Eye Center are medical assistants as defined by NAC 630.230(2)(d).

80. Dr. Chou did not provide any, let alone adequate, supervision of any of the medical technicians at Valley Eye Center as she was only in the office on Fridays and part of Saturdays during which time she performed Lasik surgeries and some post-operative care. Dr. Chou had no involvement of the training or determining the competency of any of the medical technicians at Valley Eye Center.

81. Accordingly Dr. Chou did not provide adequate supervision to medical technicians she allowed to assist in the care of patients and thus she is in violation of NAC 630.230(1)(i) and NRS 630.306(2)(b) and is subject to discipline.

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Seventeenth Cause of Action

82. All of the above paragraphs are incorporated by reference as though fully set forth herein.

83. NRS 630.301(9) provides that engaging in conduct that brings the medical profession into disrepute is grounds for initiating discipline against a licensee.

84. Dr. Chou's acts averred in this Complaint constitute conduct that brings the medical profession into disrepute, and, thus, constitutes a violation of NRS 630.301(9) for which Dr. Chou is subject to discipline.

Eighteenth Cause of Action

85. All of the above paragraphs are incorporated by reference as though fully set forth herein.

86. NRS 630.306(7) provides that continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field is grounds for initiating discipline against a licensee.

87. Dr. Chou's acts as averred in this Complaint show a continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field while engaged in practice at Valley Eye Center for which Dr. Chou is subject to discipline.

CAUSES OF ACTION RELATED TO DR. CUTARELLI

Nineteenth Cause of Action

88. All of the above paragraphs are incorporated by reference as though fully set forth herein.

89. In June 2008, Dr. Cutarelli began routinely performing Lasik surgeries at Valley Eye Center. Dr. Cutarelli lives in Colorado and maintains no residence or presence in Nevada except that he performed surgeries at Valley Eye Center. Dr. Cutarelli is not employed by Valley Eye Center; instead, Dr. Cutarelli is an independent contractor with Valley Eye Center.

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90. The normal practice of Valley Eye Center as described in paragraphs #6 and #7 herein was also the norm at all times pertinent to Dr. Cutarelli's performance of Lasik surgeries at Valley Eye Center, except that Dr. Cutarelli's day for performing surgery was not always Friday.

91. The determination of candidacy for Lasik surgery and several of the pre-operative examinations performed to make this determination are the practice of medicine and may only be performed by a licensed ophthalmologist or optometrist.

92. Dr. Cutarelli knew that Vikas Jain, a/k/a Dr. Ken, was not a physician licensed in Nevada.

93. During the time that Dr. Cutarelli performed surgeries at Valley Eye Center some pre-operative assessments were performed by a licensed optometrist, however, he failed to perform independent examinations of the patients in order to verify measurements or to determine a patient's candidacy.

94. On or about June 18, 2008, Patient N presented to Valley Eye Center. Pursuant to the procedures described in paragraphs # 6 and #7, Dr. Cutarelli performed Lasik on Patient N but failed to perform an independent evaluation of Patient N prior to performing Lasik surgery on Patient N.

95. During the procedure, Dr. Cutarelli created free flaps, a known complication of the procedure, however they were not properly placed back over the corneas.

96. Dr. Cutarelli failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances by physicians in good standing practicing ophthalmology in Nevada when he performed the Lasik surgery upon Patient N in the manner described. As a consequence of Dr. Cutarelli's failure to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances, Patient N's suffered severe damage to his eyes and may have to undergo corneal transplants in both eyes.

97. Dr. Cutarelli's treatment of Patient N as alleged constitutes a violation of NRS 630.301(4) and thus he is subject to disciplinary action being taken against him.

Twentieth Cause of Action

98. All of the above paragraphs are incorporated by reference as though fully set forth herein.

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99. Patient O presented to Valley Eye Center in August 2008 for Lasik surgery to be performed by Dr. Cutarelli. Patient O met Dr. Cutarelli for the first time in a group with other patients to discuss their upcoming procedures.

100. Several hours prior to the procedure being performed, numbing drops had been placed in Patient O's eyes in order to anesthetize them for the Lasik surgery. By the time that Patient O's surgery was performed by Dr. Cutarelli, the numbing drops had worn off. As Dr. Cutarelli began to use the Nidek laser to slice Patient O's corneas, Patient O experienced excruciating pain. It was only after the Patient O was experiencing this pain that Dr. Cutarelli placed more numbing drops in Patient O's eyes.

101. Dr. Cutarelli failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances by physicians in good standing practicing ophthalmology in Nevada when she performed the Lasik surgery upon Patient O in the manner described. As a consequence of Dr. Cutarelli's failure to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances, Patient O's suffered extreme pain during the procedure which was avoidable.

102. Dr. Cutarelli's treatment of Patient O as alleged constitutes a violation of NRS 630.301(4) and thus he is subject to disciplinary action being taken against him.

Twenty-First Cause of Action

103. All of the above paragraphs are incorporated by reference as though fully set forth herein.

104. In performing Lasik surgeries at Valley Eye Center, Dr. Cutarelli often relied upon preoperative assessments and measurements and determinations of candidacy made by a person whom Dr. Cutarelli knew was not a physician licensed in Nevada. In so doing, Dr. Cutarelli aided, assisted, and knowingly allowed an unlicensed person, namely Vikas Jain, a/k/a Dr. Ken, to engage in the practice of medicine contrary to the provisions of NRS chapter 630.

105. Dr. Cutarelli's aiding, assisting, and knowingly allowing Vikas Jain to perform pre-operative examinations on patients' eyes that should only be performed by an ophthalmologist or optometrist and allowing Vikas Jain to make determinations regarding the candidacy of some

patients for Lasik surgery, acts which constitute the practice of medicine in Nevada, constituted a violation of NRS 630.305(1)(e) and accordingly Dr. Cutarelli is subject to disciplinary action being taken against him.

Twenty-Second Cause of Action

106. Vikas Jain had had all of his medical licenses revoked as a result of his substandard ophthamological Lasik performed upon at least 22 patients in Ohio who had suffered substantial harm resultant from his substandard care. Vikas Jain, therefore, had been found by a board of his peers to be unqualified to perform ophthalmic functions related to refractive surgery.

107. In addition to constituting the aiding and assisting of unlicensed practice, Dr. Cutarelli's delegating responsibility for preoperative assessment and measurement of patients' eyes also meant that he delegated responsibility for the care of his patients to Vikas Jain, who had already shown himself to be unqualified to be involved in the care of patients seeking Lasik.

108. Dr. Cutarelli's delegating responsibility for preoperative assessment and measurement of patients' eyes also meant that he delegated responsibility for the care of Valley Eye Center patients to Vikas Jain, who has already shown himself to be unqualified to be involved in the care of patients seeking Lasik.

Twenty-Third Cause of Action

109. All of the above paragraphs are incorporated by reference as though fully set forth herein.

110. NRS 630.306(2)(b) provides that engaging in conduct with the Board has determined is a violation of the standards of practice established by regulation of the Board is grounds for initiating discipline against a licensee.

111. NAC 630.230(1)(i) provides that a physician shall not fail to provide adequate supervision of a medical assistant who is employed or supervised by the physician or physician assistant.

112. The medical "technicians" at Valley Eye Center are medical assistants as defined by NAC 630.230(2)(d).

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113. Dr. Cutarelli did not provide any, let alone adequate, supervision of any of the medical technicians at Valley Eye Center as he was only in the office one full day during a week and part of another day during which time he performed Lasik surgeries and some post-operative care. Dr. Cutarelli had no involvement of the training or determining the competency of any of the medical technicians at Valley Eye Center.

114. Accordingly Dr. Cutarelli did not provide adequate supervision to medical technicians he allowed to assist in the care of patients and thus he is in violation of NAC 630.230(1)(i) and NRS 630.306(2)(b) and is subject to discipline.

Twenty-Fourth Cause of Action

115. All of the above paragraphs are incorporated by reference as though fully set forth herein.

116. Dr. Cutarelli's acts averred in this Complaint constituted conduct that brings the medical profession into disrepute, and, thus, constituted a violation of NRS 630.301(9).

117. Dr. Cutarelli's acts averred in this Complaint constitute conduct that brings the medical profession into disrepute, and, thus, constitutes a violation of NRS 630.301(9) for which Dr. Cutarelli is subject to discipline.

Twenty-Fifth Cause of Action

118. All of the above paragraphs are incorporated by reference as though fully set forth herein.

119. NRS 630.306(7) provides that continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field is grounds for initiating discipline against a licensee.

120. Dr. Cutarelli's acts as averred in this Complaint show a continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field while engaged in practice at Valley Eye Center for which Dr. Cutarelli is subject to discipline.

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CAUSES OF ACTION REGARDING DR. ANAMIKA JAIN

Twenty-Sixth Cause of Action

121. All of the above paragraphs are incorporated by reference as though fully set forth herein.

122. Dr. Anamika Jain is the wife of Vikas Jain and was married to Vikas Jain throughout all of the time in which Vikas Jain went through the legal proceedings that ultimately resulted in the revocation of all medical licenses he had held and knew that he did not hold a Nevada license to practice medicine. Therefore, Dr. Anamika Jain knew that Vikas Jain was not licensed to practice medicine in any state.

123. All of the publicly available documents show Dr. Anamika Jain as the sole owner, officer, and principal for Valley Eye Center. Dr. Anamika Jain employed Vikas Jain at Valley Eye Center and knew of and condoned all of Vikas Jain's activities at Valley Eye Center. For example, Dr. Anamika Jain knew and condoned Vikas Jain's performing of preoperative evaluations and diagnoses and determinations of patients' candidacy for Lasik surgery by Dr. Chou and Dr. Cutarelli, evaluations and diagnoses and determinations Dr. Anamika Jain knew or should have known constituted the practice of medicine in Nevada. Dr. Anamika Jain knew and condoned Vikas Jain's representations of himself as "Dr. Ken." Dr. Anamika Jain knew and condoned that Valley Eye Center allowed Vikas Jain to perform evaluations and make determinations of candidacy that are the practice of medicine.

124. In allowing the performing of Lasik surgeries at Valley Eye Center where she knew that the ophthalmologist performing the procedure (either Dr. Chou or Dr. Cutarelli) were relying almost solely upon preoperative evaluations and measurements made by a person whom Dr. Anamika Jain knew was not a physician licensed in Nevada, Dr. Anamika Jain aided, assisted, and knowingly allowed an unlicensed person, namely Vikas Jain, to engage in the practice of medicine contrary to the provisions of NRS chapter 630.

125. Dr. Anamika Jain's aiding, assisting, and knowingly allowing Vikas Jain to perform pre-operative examinations on patients' eyes that should only be performed by an ophthalmologist or optometrist and allowing Vikas Jain to make diagnoses and determinations regarding the candidacy

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of some patients for Lasik surgery, acts which constitute the practice of medicine in Nevada, constituted a violation of NRS 630.305(1)(e) and accordingly Dr. Jain is subject to disciplinary action being taken against her.

Twenty-Seventh Cause of Action

126. All of the above paragraphs are incorporated by reference as though fully set forth herein.

127. Vikas Jain had had all of his medical licenses revoked as a result of his substandard ophthamological Lasik performed upon at least 22 patients in Ohio who had suffered substantial harm resultant from his substandard care. Vikas Jain, therefore, had been found by a board of his peers to be unqualified to perform ophthalmic functions related to refractive surgery.

128. In addition to constituting the aiding and assisting of unlicensed practice, Dr. Anamika Jain's delegating responsibility for preoperative assessment and measurement of patients' eyes as well as diagnoses and determinations of candidacy for the procedure, also meant that she delegated responsibility for the care of Valley Eye Center patients to Vikas Jain, who has already shown himself to be unqualified to be involved in the care of patients seeking Lasik surgery.

129. Dr. Anamika Jain's delegating or allowing of performance of preoperative evaluations that should only be performed by a licensed ophthalmologist or optometrist and diagnosis and determination of candidacy for the procedure to Vikas Jain when she knew him to be unqualified to perform such tasks constitutes a violation of NRS 630.350(1)(f).

Twenty-Eighth Cause of Action

130. All of the above paragraphs are incorporated by reference as though fully set forth herein.

131. NRS 630.306(2)(b) provides that engaging in conduct with the Board has determined is a violation of the standards of practice established by regulation of the Board is grounds for initiating discipline against a licensee.

132. NAC 630.230(1)(i) provides that a physician shall not fail to provide adequate supervision of a medical assistant who is employed or supervised by the physician or physician assistant.

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133. The medical "technicians" at Valley Eye Center are medical assistants as defined by NAC 630.230(2)(d).

134. Dr. Anamika Jain did not provide adequate, supervision of any of the medical technicians at Valley Eye Center as she has no training or background in ophthalmology and accordingly was not qualified to supervise, train or determine the competency of any of the medical technicians at Valley Eye Center.

135. Accordingly Dr. Jain did not provide adequate supervision to medical technicians she allowed to assist in the care of patients and thus she is in violation of NAC 630.230(1)(i) and NRS 630.306(2)(b) and is subject to discipline.

Twenty-Ninth Cause of Action

136. All of the above paragraphs are incorporated by reference as though fully set forth herein.

137. Dr. Anamika Jain's acts averred in this Complaint constituted conduct that brings the medical profession into disrepute, and, thus, constituted a violation of NRS 630.301(9).

138. Dr. Anamika Jain's acts averred in this Complaint constitute conduct that brings the medical profession into disrepute, and, thus, constitutes a violation of NRS 630.301(9) for which Dr. Jain is subject to discipline.

WHEREFORE, the Investigative Committee prays:

1. That the Nevada State Board of Medical Examiners hold a formal hearing on February 23, 2009;

2. That the Nevada State Board of Medical Examiners give Respondents notice of the charges herein against them, the time and place set for the hearing, and the possible sanctions against them;

3. That the Nevada State Board of Medical Examiners determine what sanctions it determines to impose for the violation or violations committed by Respondents; and

4. That the Nevada State Board of Medical Examiners make, issue and serve on Respondents its findings of facts, conclusions of law and order, in writing, that includes the sanctions imposed; and

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5. That the Nevada State Board of Medical Examiners take such other and further action as may be just and proper in these premises.

DATED this 19th day of December, 2008.

THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Lyn E. Beggs
Lyn E. Beggs
General Counsel and Attorney for the Investigative Committee

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF DOUGLAS)

CHARLES N. HELD, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint against Respondent are true, accurate, and correct.

DATED this 19th day of December, 2008.

CHARLES N. HELD, M.D.

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CERTIFICATE OF MAILING

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on the 19th day of December 2008, I served a file copy of the AMENDED COMPLAINT & copy of the AMENDED PATIENT DESIGNATION, by mailing via USPS certified mail & facsimile to the following:

Nathan A. Crane, Esq.
Peter Stirba & Associates
PO Box 810
Salt Lake City, UT 84110-0810

Kathleen Janssen, Esq.
3883 Howard Hughes Parkway, Ste. 1100
Las Vegas, NV 89169

Diane Carr Roth, Esq.
Jennings, Strouss & Salmon, PLC
8330 West Sahara Ave., Ste. 290
Las Vegas, NV 89117-8949

Via USPS regular mail:

Jill Greiner, Hearing Officer
2915 Sagittarius Dr.
Reno, NV 89509

Dated this 19th day of December 2008.

Angelia Donohoe

Angelia Donohoe
Legal Assistant

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